MEWA Trust Termination Service Request Form

Please use this form to terminate a subscriber or dependent's eligibility status.

Participating Association Name: _____

Section I: Employee (Subscriber) Information

Employee Name	Social Security No.	Group/Employer Name

Section II: Terminating Coverage

Select the coverage being terminated:

☐ **Medical**	☐ **Dental**	☐ **Vision**	☐ **Vol. Life Insurance**
☐ Employee ☐ Spouse ☐ Dependent(s)	☐ Employee ☐ Spouse ☐ Dependent(s)	☐ Employee ☐ Spouse ☐ Dependent(s)	☐ Employee ☐ Spouse ☐ Dependent(s)
☐ **Short Term Disability**	☐ **Long Term Disability**	☐ **Base Life/AD&D**	☐ **Critical Illness**
☐ Employee ☐ Spouse ☐ Dependent(s)	☐ Employee ☐ Spouse ☐ Dependent(s)	☐ Employee ☐ Spouse ☐ Dependent(s)	☐ Employee ☐ Spouse ☐ Dependent(s)
☐ **Hospital Indemnity**	☐ **Accident**		
☐ Employee ☐ Spouse ☐ Dependent(s)	☐ Employee ☐ Spouse ☐ Dependent(s)		

Employee term date: _____

Name of spouse to be terminated: _____

Termination date: _____

Name(s) of dependent to be terminated: _____

Termination date: _____

Section III: Termination Information

Reason for Termination: *Check all that apply. If termination is voluntary, employee signature is required.*

☐ Terminated employment ☐ Retirement ☐ Death ☐ Eligible for Other Coverage ☐ Divorce
☐ Dependent Status Change ☐ Other

Employee Signature	Date (MM/DD/YYYY)
X	

Section IV: Signature of Group Administrator

I represent that the statements on this form are true, complete and accurately recorded to the best of my knowledge.

Print Group Administrator Name	Group Administrator Signature (Required)	Date (MM/DD/YYYY)
	X	